Psychotherapy and Confidentiality

Ralph Slovenko
ARTICLES

PSYCHOTHERAPY AND CONFIDENTIALITY*

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DOES THE PSYCHIATRIST TALK TOO MUCH? Does the modern practice of psychiatry threaten confidentiality? Whatever disagreement may exist regarding the methods used by a therapist in the course of psychotherapy, there is a near unanimity of opinion among therapists that nothing about a patient should be divulged to third parties. Allegedly, the patient's full participation, essential to psychotherapy, cannot be obtained without an assurance of absolute confidentiality.¹

Central to a discussion on confidentiality is an examination of whether therapists are concealing what should be told and revealing what ought to be kept confidential. When may the therapist divulge, when should he divulge, and when must he divulge? Although adopting the stance of protecting the patient's privacy and creating a "safe atmosphere" for all potential patients, it is possible that the therapist is equally concerned with his own privacy and method of practice. At times it may be that the therapist's self-gratification prompts divulgences. These concerns of the therapist are legitimate, to be sure, but may do little to further the best interests of the patient.

The traditional confidentiality between the physician/psychiatrist and his patient is said to be threatened by the growing complexity of health care and the utilization of computers. The number of recent page-one articles in Psychiatric News, the bi-weekly newspaper of the American Psychiatric Association, indicates that privileged communication and confidentiality are high-priority issues among psychiatrists. At the invitation of Dr. Alfred M. Freedman, then president of the American Psychiatric Association, representatives of various psychiatric, psychological, medical, hospital, legal, and insurance associations met during 1973 and

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¹ A recent book review in a professional journal quoted several remarks made to a group of students by one of Freud's colleagues, Dr. Sandor Rado, about his analysand, Dr. Otto Fenichel. Rado stated Fenichel was one of the most obsessional individuals he had ever attempted to psychoanalyze, and that he considered the analysis a failure. This quote prompted much criticism. In response to the criticism, the reviewer replied, "But what was it that was really revealed in my review?" THE ACADEMY, Sept. 1974 at 5. Marvin Drellich, in a letter to the editor, responded by pointing out that such a question "betrays his failure to comprehend that confidentiality must be complete and absolute." THE ACADEMY, Feb. 1975 at 5.
1974 to consider alternative methods to cope with the growing threat to the confidentiality of health records. These meetings had the benefit of numerous state society conferences and task force investigations. In addition, local hospitals and psychiatric societies in various states had been formulating protocol on preserving confidentiality. The meetings resulted in the recommendation that a national commission on the preservation of confidentiality of health records be established, but it is not yet clear what such a commission would do to preserve confidentiality.2

The A.P.A. Task Force on Confidentiality confirmed that a court demand for information worries psychiatrists most, but apart from statutory disclosure requirements and judicial compulsion, there is no legal obligation to furnish information—even to law enforcement officials. It is the individual himself who makes the disclosures or authorizes his psychiatrist to make them in order to receive benefits such as employment,3 a driver’s license, charge accounts,4 welfare benefits or insurance.5


3 For example, an applicant for admission to the Bar is asked: “Have you ever been a voluntary patient in any sanitarium, hospital or mental institution for the treatment of mental illness? If so, attach statement giving full explanation, including name and address of doctor and institution.”

The U.S. Supreme Court recently denied a petition for a writ of certiorari in the case of Anonymous v. Kissinger, 420 U.S. 990, (1975), which involved a Peace Corps worker whose appointment to a supposedly sensitive State Department position was contingent on a security clearance. The applicant answered negatively to the standard question, “Have you ever had a nervous breakdown or have you ever had medical treatment for a mental condition?” Finding this to be a false answer, the State Department demanded disclosure of his medical records. He refused, and was dismissed. Psychiat. News, May 7, 1975, at 1, col. 1.

4 [C]ommercial inquiries into the private affairs of individuals have become accepted as part of the price people pay for living in a credit-oriented society. . . . [A]s the amount of credit extended to consumers has grown, so has the business of investigating consumers’ personal affairs. Such inquiries embrace not only debts and assets and buying habits but also employment records, medical records, and personal lives—the last often in astonishingly intimate detail. For the most part, such information is collected by private agencies on behalf of a widespread corporate clientele . . . .

Generally, the agencies that specialize in collecting information on consumers are of two kinds—credit bureaus and consumer-investigation agencies. Credit bureaus report to their clients—department stores and other retailers, businessmen, banks, credit-card companies, finance companies—what is known as ledger information on consumers; that is, information from existing records on how a consumer who has applied for credit has been paying his bills . . . .

The second kind of company—the consumer-investigation agency—sells an essentially different service, which is the compilation and dissemination of reports on applicants for various kinds of insurance and the claims arising out of such insurance; it also reports on applicants for employment with private companies, and some home mortgages and apartment leases. . . . [M]any of the reports do more than verify applicants’ answers to questionnaires; they purport to describe, among other things, the character, the reputation, the general style of life and work, the medical condition, the housekeeping habits, the drinking habits, and even the sexual habits of the people involved.
I. THIRD-PARTY PAYERS, SUPERVISION AND CONFIDENTIALITY

A survey of psychiatrists in northern California reveals that inquiries from insurance companies constitute the greatest third-party involvement. Increased insurance coverage for health care is precipitating the concern with confidentiality and the conceptual model of psychiatric practice. Because of their concern about being paid by the insurance companies for their work, there is a resurgence in American psychoanalysis to link psychoanalysts more closely with physicians.

In order to provide coverage for any treatment, an insurance carrier must be able to obtain information with which it can assess the administration and costs of programs. Statistics provide the predictability which is at the heart of the insurance process. By having the medical model associated with psychoanalysis, insurers expect to receive information comparable to that for physical disorders. They expect reports "to verify that illness or disease is present." Indeed, some insurers use the same forms for cases involving surgery as for those involving psychiatric treatment — illustrative of how rhetoric not only expresses but shapes our ideas and actions.

Freud had warned that in psychotherapy, the doctor is not a doctor, and the patient is not a patient. Quite logically then, if psychiatry were considered to be the re-education of a demoralized individual

Probably fifty million investigative reports on citizens are currently in the files of commercial consumer-investigation agencies, and this number does not include several million investigative reports compiled by large corporations themselves or by private detective agencies specializing in the investigation of people who have applied for employment.

Whiteside, A Reporter at Large: Anything Adverse?, The New Yorker, April 21, 1975, at 45.

The usual waiver to release information for insurance reads: "I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment." Medical records are obtained by a centralized organization called the Medical Information Bureau, which was created by insurance companies. Records, in summary form, wind up in a computer bank, which may be made available to any of the seven hundred life-insurance companies that are subscribers to the Bureau. "[The] medical information may be used by the insurance industry to make decisions that profoundly affect people's livelihoods and lives." Whiteside, A Reporter at Large: Anything Adverse?, The New Yorker, April 21, 1975, at 47.


Identifying psychiatric care with medicine, insurance carriers do not cover the services of social workers (and often of psychologists) unless care is overseen by a physician. Obviously, the development of insurance plans presents new economic considerations which can foster or hinder certain types of care. Payments by a patient to either a psychiatrist or psychologist qualify under the Internal Revenue Code as a medical tax deduction. Chodoff, The Effect of Third-Party Payment on the Practice of Psychotherapy, 129 Am. J. Psychiat. 540 (1972); Restak, Psychiatry in Search of Identity, N.Y. Times, Jan. 12, 1975, § E, at 9, col. 2.

rather than the treatment of a disease, a different type of report would be expected. Assume for a moment that education were an insured activity. Would the insurer ask the educator to provide a diagnostic category and a report on the style of instruction? Probably not, but through the use of a medical model, the insurer asks for this information and assumes that it is a safeguard. The assumption that the right name or label gets to the essence of and gives insight into the person or situation labeled pervades every aspect of life. Our national motto could be, "In Labels We Trust." Insurance carriers believe that psychiatric labeling assures that the psychiatrist "has control over the problem and knows what to do with it."

A diagnostic label, in theory, provides a description or diagnosis, an etiological explanation, and a prognosis. In considerable measure, a medical label, e.g., diabetes, does furnish such a description, information about etiology, suggested treatment, and prognosis. Some assume that psychiatric labels do the same. In fact, a psychiatric label bears no relevance to the insurer's concerns and almost no relevance to clinical status, prognosis, or treatment. Given the same label, the treatment may be drug therapy, electroshock, or hospitalization. Psychiatrists are bemused by the question, "How long do you keep an average schizophrenic in the hospital?" Psychiatry has been debating whether its diagnostic categories are useful for psychiatry, but however that is resolved, labels assuredly are useful for neither law nor insurance. For example, since an insurer provides no coverage for treatment of "marital maladjustment," the psychiatrist searches for a classification that is covered, such as "anxiety neurosis." Consequently, the insurer increasingly asks for more information. Should the insurer ask how the transference and countertransference are developing? Not even a full psychiatric report would enlighten the insurer as already he does not know what to make of the information received. What would alleviate the insurer's concern with over-utilization of services is adequate supervision.

As the number of people covered by insurance increases, reports will become more and more bureaucratized and will have less and less meaning. Even at the present time the insurer lacks the information that would be most important and valuable — namely, how much time did the psychiatrist actually spend with the patient. Insurers acknowledge that they do not receive an accurate account of this. A bill of $40-$50

9 Apropos is the story of one husband who said to his wife, "Dear, I've been working days and nights for 30 years. Henceforth, I'm going to spend my evenings with you." Within two or three hours of the first evening, the husband talking constantly, the wife exclaimed, "Stop! I can't stand it anymore. I can absorb no more. Leave me alone." Rather soon, we may suspect, insurance companies will be saying the same.

10 Aetna Life and Casualty, second only to Blue Cross-Blue Shield as a provider of health care insurance under the Federal Employees Health Benefits program, recently advised that it is cutting back its outpatient mental health coverage for 1975, but has indicated to the American Psychiatric Association that it will favorably consider lifting these restrictions in 1976 if there is sufficient progress in peer review efforts for mental health services. Psychiat. News, Jan. 1, 1975, at 11, col. 2.

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an hour is currently deemed reasonable and customary and the insurer assumes that a bill for this amount represents an hour's service. In fact, during that hour, the psychiatrist may have seen the patient for only a few minutes in a sanitarium or may have seen the patient along with ten to fifteen other people at the same time. A time clock would far better serve the interest of the insurer than the report now presented. A report on the diagnosis or type of therapy, whether a Freudian analysis or a primal scream, is not helpful. A charge is justified and best substantiated by a simple statement of the actual time spent with a patient, and whether it was an individual or group session. This is now being required by some insurers in some areas.

Where the employer pays a part or all of the employee's insurance premium, the employer receives information to justify his cost (actually paid for by the employee through his labor). Through the efforts of the A.P.A. Task Force on Confidentiality, representatives of the Health Insurance Council have agreed to supply employers with "experience reports" that omit any data identifying the employees who created the expenses on the program. Though aggregate reporting is the prevailing practice, there are some instances when high-risk employees have been identified to the employer who then discharged them in order to obtain a lower premium. Such practice discourages an employee from seeking psychiatric help even though the costs are covered by insurance.

When an insurer is called upon to pay disability benefits under a compensation plan he wants to know whether a condition exists that prevents the claimant from working at his usual job. For example, a person in the course of his employment loses an arm. He may be able to return to work using his other arm, but he may claim that he has developed a phobia about returning to the place. A psychiatric examination is requested. (One who visits a psychiatrist for the purpose of obtaining a report does not expect and does not receive a promise of confidentiality.) Other verification through witnesses is usually available, but the insurer finds it easier to substantiate the claim on the basis of a psychiatric report. In such cases the psychiatric report often appears as stereotyped a production as the pleadings of an attorney.

The general practice of insurers is that the confidentiality of records is maintained and information about a patient is guarded. Under prevailing practice, the records are confined to the medical department of the insurance company. One wonders whether the concern over con-

12 An attorney representing the claimant-patient is entitled to see the report.
13 One insurance agent advises that to his knowledge there has been only one case where
fidentiality, vis-à-vis a third-party payer, is designed to protect the interest of the patient or that of the therapist. The oaths of Hippocrates and Maimonides represent sacred commitments that they will, "as long as they live, protect not themselves nor their profession, but their patients."14

In law, as a general principle, the privacy of a fiduciary is justified only to the extent that it serves the interests of the beneficiary. In discussing the testimonial privilege, the courts have said that the privilege exists solely for the patient’s benefit.15 A person may want some things known by nobody; other things he may not mind having disclosed to strangers. To paraphrase George Orwell, some confidential matters are more confidential than others. The available evidence indicates that patients are not concerned about the divulgence of that type of information needed to justify a bill to a third-party payer, to review the competency of the therapist, or to provide material for follow-up and research.16 The public is primarily concerned about the delivery, quality and cost of health care (psychiatric or medical), and only marginally concerned about privacy.17

In large measure, concern over privacy is a reflection of one’s sense of security. Bob Slocum, the corporate executive, in Joseph Heller’s Something Happened spends his working life fearing and distrusting his associates, all 120 of them.18 The insecurity or social paranoia upon which secrecy feeds, makes sharing of problems and learning to accept oneself difficult.

Considering the social milieu, confidentiality in psychotherapy is essential. To consider confidentiality as an absolute, however, would impede the “quality control” of care. “Quality control” necessitates a review of individual patients and therapists and involves, not indiscriminate, but discriminate disclosure. The therapist in training must “breach” the confidence of his patient in order to discuss the case with his supervisor.19 Judicially ordained right-to-treatment envisions individualized

the health records of an insured were permitted to be seen indiscriminately by employees of the insurance company, and that dealt with the x-rays of Elizabeth Taylor’s breast which she insured for $13 million when going to Italy to film “Cleopatra.” The insurance company people felt that “Miss Taylor’s bosom was worth every cent of the policy.”

14 Knight, The Medical Connection, 6 Tulane Medicine 7 (1974).
17 Quite likely, when an analyst says, “Now just relax and say the first thing that comes to your mind,” the analysand is thinking, “The money that this is costing me.”
18 Since the psychiatrist is often regarded as a modern-day confessor, it may be noted that in an earlier time, and still today in some societies, there was a practice of collective confession of sins. That practice is based on the idea that mankind is one, and therefore all men are bound up with each other. The collective confession made everyone fully aware of his own sins and also emphasized his share of guilt in the wrongs committed by others. Those confessions were not mere pro forma as is found in many churches today where there is a routine congregational confession of sin. The rise of individualism gave impetus to the penitent in isolation, and it has tended to dwarf mass confession as an effective method of relief from guilt. J. A. Knight, Conscience and Gilt 118 (1969).
19 Indeed, the husband-wife marital relationship is not considered to be inhibited because

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treatment for institutionalized patients based on programs submitted for review to a mental health board. In an attempt to ensure that the data would not go beyond the board, a code system was used by some states to conceal the names of patients and therapists. The system proved unmanageable. (In any event, the value of supervision based on reports is dubious as such reports tend to be self-serving declarations.)

Confidentiality is also an obstacle to research. The Michigan mental health code, for example, provides that information shall be disclosed:

as necessary for the purpose of outside research, evaluation, accreditation, or statistical compilation, provided that the person who is the subject of the information can be identified from the disclosed information only when such information is essential in order to achieve the purpose for which the information is sought or when preventing such identification would clearly be impractical, but in no event when the subject of the information is likely to be harmed by such identification.

But try to implement the provision! With no time limit in which the request must be acknowledged, the researcher is often exhausted in his efforts to obtain any compliance. Year in and year out law students meet a stone wall of resistance in their attempt to check on hospital or aftercare treatment programs. Without the names and addresses of the patients, follow-up is impossible. Although most of the patients would be delighted to meet with the students, the hospital staff, perhaps understandably, is unwilling to expend the time and effort needed to contact the patients and obtain their approval. It is a foregone conclusion that the researcher will receive no cooperation from the private practitioner. Follow-up studies might focus on the allegation that psychotherapists "go merrily along from failure to failure." "If psychotherapy were a drug," it is said, "the FDA would ban it." As things stand, only the subpoena brings forth information, and then only when the patient becomes involved in litigation and his condition is in issue.

one of the spouses divulges all of the bedroom secrets to a therapist. Erica Jong writes about her _menage à quatre_ — herself, her analyst, her (now ex-) husband, and his analyst. "Four in a bed," she writes, "This picture is definitely rated X." E. Jong, _Fear of Flying_ 7 (1973).


22 Consider the following example: "I am not at liberty to provide you with a listing of Community Living facilities servicing patients from this institution as this would violate our contract with the Community Living sponsors." Letter from the office of the superintendent, Northville State Hospital, Northville, Michigan to author, Feb. 10, 1975. On hospital practices, Herbert M. Silverberg, recalling his service as counsel for patients at St. Elizabeth's Hospital, reports that one psychiatrist there sought commitment only of young women. This type of finding only comes about from a profile of practice, not from an individual study of a case. Silverberg, _Protecting the Human Rights of Mental Patients: One Lawyer's Experience in a World of Psychiatrists_, _BARRISTER_, Fall 1974, at 46. _See also_ Greenburg, _Involuntary Psychiatric Commitments to Prevent Suicide_, 49 _N.Y.U.L. Rev._ 227, 250, 256 (1974); Sheridan, _Why the Lawyers Caught Nork and the Doctors Didn't_, _MED. ECONOMICS_, July 22, 1974, at 91.
II. WRITING ABOUT PATIENTS

An author of books or articles about a patient shares an acquisition of knowledge and experience, providing information which may be of value to other professionals and to the public generally. Writing a case history of a psychiatric patient, however, without breaching the confidentiality of that relationship is no easy matter. Unlike physical ailments which can be discussed without anyone recognizing the patient, psychiatric ailments usually entail discussion of distinguishing characteristics. In Notes Upon a Case of Obsessional Neurosis, Freud pointed out that the composition of a case history was rendered difficult due to inevitable compressions, as well as the need for greater discretion in print. He was especially limited since the patient was well known in Vienna. In his opening remarks, Freud observed that discussion of intimate secrets was less likely to lead to identification of the patient than the trivial everyday details of personality. Yet it is just these details that are essential in tracing the individual steps in an analysis.

23 It is also no easy matter for lawyers to write about their clients. Consider: M. A. Musmanno, VERDICT! (1958); L. Nizer, MY LIFE IN COURT (1961); Gertz, The Jack Ruby Case — A Decade Later, 63 ILL. BAR J. 150 (1974). Louis Nizer says: “In view of the fact that trials constitute public records, there is no need for the approval of those who are involved. However, as a matter of ethics, I have never written about a client without having the client’s written authority and approval.” Letter from Louis Nizer to author, Oct. 7, 1974.

24 Freud wrote:

[T]he presentation of my case histories remains a problem which is hard for me to solve. . . . If it is true that the causes of hysterical disorders are to be found in the intimacies of the patients’ psychosexual life, and that hysterical symptoms are the expression of their most secret and repressed wishes, then the complete elucidation of a case of hysteria is bound to involve the revelation of those intimacies and the betrayal of those secrets. It is certain that the patients would never have spoken if it had occurred to them that their admissions might possibly be put to scientific uses; and it is equally certain that to ask them themselves for leave to publish their case would be quite availing. In such circumstances persons of delicacy, as well as those who were merely timid, would give first place to the duty of medical discretion and would declare with regret that the matter was one upon which they could offer science no enlightenment. But in my opinion the physician has taken upon himself duties not only towards the individual patient but towards science as well; and his duties toward science mean ultimately nothing else than his duties towards the many other patients who are suffering or will some day suffer from the same disorder. Thus it becomes the physician’s duty to publish what he believes he knows of the causes and structure of hysteria, and it becomes a disgraceful piece of cowardice on his part to neglect doing so, as long as he can avoid causing direct personal injury to the single patient concerned. I think I have taken every precaution to prevent my patient from suffering any such injury. I have picked out a person the scenes of whose life were laid not in Vienna but in a remote provincial town, and whose personal circumstances must therefore be practically unknown in Vienna. I have from the very beginning kept the fact of her being under my treatment such a careful secret that only one other physician — and one in whose discretion I have complete confidence — can be aware that the girl was a patient of mine. I have waited for four whole years since the end of the treatment and have postponed publication till hearing that a change has taken place in the patient's life of such a character as allows me to suppose that her own interest in the occurrences and psychological events which are to be related here may now have grown faint. Needless to say, I have allowed no name to stand which could put a non-medical reader upon the scent; and the publication
Psychiatric journals, as a precautionary measure, usually advise contributors that it is the responsibility of the author to disguise the identity of the patient. Even so, the skill of Sherlock Holmes is not required to identify the subject of an article by a psychiatrist living in the same community, the large metropolis excepted. The fictionalization of all names, including the author’s, is a precautionary measure, but it is a sacrifice for any author to write anonymously, however strong the desire to share knowledge. The anonymous author of Confessions of a Gynecologist says that anonymity is expected of the gynecologist who reveals the secrets of his patients and what he really thinks about women — particularly if he desires to remain in practice.

The United States Supreme Court in 1974 accepted for review an action initiated by a psychiatric patient to prevent the publication of a book by her therapist. The book, entitled In Search of a Response, of the case in a purely scientific and technical periodical should, further, afford a guarantee against unauthorized readers of this sort. I naturally cannot prevent the patient herself from being harmed if her own case would accidentally fall into her hands. But she will learn nothing from it that she does not already know; and she may ask herself who besides her could discover from it that she is the subject of this paper.


Of the six case histories published by Freud, one was rejected by the editor of the first journal to whom he sent it, apparently on the ground that it was a breach of discretion. These case histories read like detective thrillers and some carry a sensational nickname (e.g., “The Rat Man,” “The Wolf Man”), but each had a specific scientific purpose. Each is a classic in psychoanalytic literature. One case history was based not upon a patient of Freud’s but upon published literature. Freud was apparently unconcerned about public reprimand or a defamation suit, although the subject, Dr. Daniel Paul Schreber, whose name was used, was paranoid (the litigious type of personality), a magistrate and a member of a distinguished family. This was the forerunner of “long-distance” psychoanalytic studies such as those on Hitler, Nixon, and Luther.


All the names in the recent book, Admissions: Notes from a Woman Psychiatrist, including the author’s, are fictionalized. Perhaps the author assumed a pseudonym because she describes her own affair with a married man.

Anonymous M.D., Confessions of a Gynecologist (1972). The observation has been made that “psychiatrists do more harm by selling the secrets of their patients to national magazines than they do by disclosing them in court.” In Philip Roth’s My Life as a Man, a patient in the waiting-room of his psychiatrist’s office, opening a magazine, is upset to find an article by the psychiatrist about him. The patient’s identity was changed from Jewish to Italian, but that was not much of a disguise, considering their common Mediterranean traits.

About medic-writers in general, it is observed: “When you think the doctor is just taking your medical history, he may really be drafting his next chapter, because doctors nowadays apparently carry typewriters in their little black bags.” Mather, On Books, Detroit Free Press, April 6, 1975, § B, at 5, col. 1.

revealed the history of the plaintiff and her family and was based on a near-verbatim record of her seven years of analysis. The breakdown of her marriage and various humiliating sexual experiences were described. The psychiatrist used a pseudonym only for the patient and quoted extensive conversations. The patient, a university social work professor, brought the lawsuit anonymously (Roe v. Doe), charging that the publication of the book, which appeared briefly before the suit was filed, violated her right of privacy and the confidential nature of the doctor-patient relationship.

Giving credence to the defendant’s claim that the disclosure was of scientific value, the New York trial court formulated an innovative remedy. It enjoined only that portion of the book’s distribution reasonably calculated to reach the nonscientific reader. Assuming the book to be of scientific value — it is not for a judge to rule otherwise — the trial court limited the book’s distribution to the scientific community, i.e., universities, medical schools and other institutions of learning, including psychiatry, psychology, social work and related fields and associated book stores. The New York appellate court, however, found no justification for the distinction drawn by the trial court between “scientific readers” and the general public; it concluded that the plaintiff was entitled to either full protection or no protection at all, and enjoined all distribution of the book.30

The issue, as presented to the Supreme Court, was the propriety of a prior restraint on free expression in order to protect privacy or confidential information. That was not an entirely new issue. The constitutional guarantee of freedom of speech is not an absolute and publications may be subject to prior restraints. Thus in one case, the publication of a book by a former employee of the Central Intelligence Agency exposing information which he had sworn to keep secret was enjoined. In response to the defendant’s argument that an injunction was not necessary and that other relief would be more appropriate, the Court of Appeals for the Fourth Circuit ruled: “the risk of harm from disclosure is so great and maintenance of the confidentiality of the information so necessary that greater and more positive assurance is warranted.”31

30 Though an irrelevant consideration in light of the position taken by the New York appellate court, it may be noted that the defendant’s manner of advertising and selling the book contradicted the avowed purpose of advancing solely scientific knowledge. The advertisements were of the type used to herald a popular novel rather than a scientific treatise on the treatment of schizophrenia. The United States Supreme Court in a much publicized obscenity case, Ginzburg v. United States, 383 U.S. 463 (1966), focused on the method of marketing. In this case the court found that the seller, Ralph Ginzburg, made a business of pandering to the widespread weakness of titillation by pornography. Ginzburg was estopped from establishing that the book, which he represented as obscene by advertising, was not actually obscene under the then prevailing legal test of obscenity. In effect, the court ruled, the tail may wag the dog.

31 United States v. Marchetti, 466 F.2d 1309, 1317 (4th Cir. 1972). In this case the author, Victor Marchetti, when he joined the C.I.A., like employees at various federal agencies, signed a contract pledging secrecy as to what he learned while with the C.I.A. After he left the agency 14 years later, in 1969, he started writing a book about it and submitted an outline to some publishers. The agency learned about it and sought an
mental matters the courts have enjoined disclosure of trade secrets by employees who have learned those secrets in the course of employment.\textsuperscript{32}

The Center of Law and Social Policy and the Mental Health Law Project filed an amicus curiae brief in the Supreme Court supporting the plaintiff-patient on behalf of the American Psychiatric Association, the American Psychoanalytical Association, and the American Orthopsychiatric Association.\textsuperscript{33} In a relatively unusual action, after hearing oral arguments, the Court decided not to resolve the dispute. No reason was given for the dismissal, other than the usual recital that the order accepting the case had been "improvidently granted."\textsuperscript{34} The grapevine has it that the case record was "inadequate and confused."\textsuperscript{35}

injunction. The Fourth Circuit Court of Appeals said that the first amendment was no bar to an injunction forbidding disclosure of classified information when the information was learned during government employment and the employee had signed a secrecy contract. The decision was criticized as an undue restriction on free speech by Anthony Lewis.\textsuperscript{36} The Supreme Court declined review of the case. United States v. Marchetti, 409 U.S. 1063 (1972).

Recent amendments to the Freedom of Information Act apparently shift the burden of proof in challenges of classification to the Government, i.e., whether a fact that has been classified as secret is actually subject to classification.\textsuperscript{37} N.Y. Times, March 16, 1975, at 48, col. 7. In Totten v. United States, 92 U.S. 105 (1875), which arose after the Civil War, the Supreme Court held that a suit against the Government for compensation for service as a spy could not be maintained since "... public policy forbids the maintenance of any suit ... which would inevitably lead to the disclosure of matters which the law itself regards as confidential ...."\textsuperscript{38}

\textsuperscript{32} See also Galella v. Onassis, 487 F.2d 986 (2d Cir. 1973), where an injunction issued to protect the privacy of Jacqueline Kennedy Onassis against the intrusions of a commercial photographer.

\textsuperscript{33} Dr. Alfred M. Freedman, chairman of the A.P.A.'s Working Group on Confidentiality, wrote the following comment in a national legal newsmagazine:

\textit{[W]hile there is an attempt in the book to disguise Jane Doe, this obscuring apparently was not successful. According to the record, the book contains "numerous identifying characteristics such as age, religion, educational institutions attended, professional interests and accomplishments." There is even a reference to the locale of the patient's home in the Introduction. Other persons have also indicated that they were able to identify the patient.}

Freedman, \textit{Looking Over the Doctor's Shoulder}, 11 TRIAL 28, Jan./Feb. (1975). The psychiatrist-author, Dr. Leida Berg (her name is now a matter of public record), complained that the A.P.A. justified its participation in the amicus brief in the Supreme Court accepting "as fact the allegations and misrepresentations of plaintiff and her attorneys without ascertaining the complete and true facts." She claimed that the patient could not be identified and that the injunction blocked the flow of scientific information. "[T]here must be a few thousand women who could match the age, religion, educational institutions attended, and professional interests and accomplishments of the patient in (our) book." She further asserted that the A.P.A. Executive Committee had an obligation to stand behind [her] and to affirm [her] right to publish a worthwhile book, ten years after treatment was discontinued — a book in which the identities were carefully disguised ... [T]hey have an obligation to APA membership to encourage, not stifle, the spirit of free inquiry. Psychiat. News, Jan. 1, 1975, at 10.

\textsuperscript{34} Roe v. Doe, 420 U.S. 307 (1975).

\textsuperscript{35} Marvin Karpatkin, counsel for complainant, died suddenly in January, 1975, before the Supreme Court acted on the case. His colleague, Steven Delibert, who worked with him on the case, advises:

\textit{We have not previously devoted much thought as to why the Court might have}
Although *Roe v. Doe* was not a tort suit for malpractice or invasion of privacy, which may occur in the event of distribution of the book, it may be appropriate to formulate the following questions which should be answered in disputes arising between the psychiatrist and patient. Does the therapist unduly prolong treatment in order to obtain material for the book? Is the treatment situation skewed with interpretations in order to get material for the book? Are notes which might inhibit the therapeutic relationship taken in order to supply material for the book?

Decisive in cases such as *Roe v. Doe* is the patient's consent to the publication. The patient who consents with full knowledge may be considered a joint venturer (although he does not share in the profits). In this case, the psychiatrist-author claimed that the patient gave oral consent to publication approximately eleven years before the book was published. The complainant argued that even if consent had been given, it should not be given effect because it was given during therapy. Consent at such a time is meaningless, according to the argument, for there is little likelihood of an informed, voluntary agreement in view of the patient's emotional dependency upon the therapist and the submissive attitude induced by the treatment.\(^{36}\)

Without adequate disguise, consent of the patient to publication is required. What is to be considered an adequate consent? The law distinguishes between a particular retrospective waiver and a general prospective waiver. The latter, though written, and now quite commonly obtained in medical and psychiatric practice, may not stand up in court. The more the hazards are unknown, the more likely that a prospective waiver will be void for want of an informed consent. Pragmatically, however, such consent may dissuade the legally unsophisticated from making a complaint.

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avoided a decision on the merits of *Roe v. Doe*, and we really are not convinced we have the right answer, but our best opinion is that the Court finally was of the feeling that it could not decide the merits of the preliminary injunction without reaching some of the very complex privacy versus press questions raised on the merits of the case. While we tried very strenuously to focus the Court's attention on the narrow question which we believed the case to present, of whether a preliminary injunction against publication might issue where the facts are not clearly resolved, the Court apparently was impressed with the *amicus* brief of the APA *et al.* which urged that all consideration of the case be postponed until the facts were more fully developed. Letter from Steven Delibert to author, April 3, 1975.

Ephraim London, counsel for defendant, puts it this way:

We believe the Court dismissed the petition because it concluded that a substantial question was not presented. Because of the procedures followed in the New York Court of Appeals and the United States Supreme Court, the petitioners limited the issue in the case to the question of whether every preliminary injunction against publication of a book infringes the First Amendment guarantees. On the argument, counsel for the petitioners conceded that in some circumstances a preliminary judgment may be permissible. After the argument, I bet a total of 50 cents with ten people that the petition would be dismissed on the ground that *certiorari* was improvidently granted. Letter from Ephraim London to author, April 3, 1975.

Finally, the publication of case histories gives the public the impression that copious notetaking is an intrinsic part of the psychotherapeutic process and that there is valuable information in those records.37

III. DIVULGENCE TO SAFEGUARD THE PATIENT OR OTHERS

What of the situations where the psychiatrist becomes an informer in order to protect the patient or others? The Hippocratic Oath, by implication, provides an exception when certain matters should be revealed. As oft-noted, Hippocrates did not forbid all revelations under any circumstances.

A highly visible divulgence recently occurred when Norman Mailer, considered by some to be the nation's leading author, published a biography of Marilyn Monroe. In it he surmised that the actress may have been murdered and that she might have been having an illicit affair with the late President John F. Kennedy or his brother Robert Kennedy, or both.38 Mailer suggested that the CIA could have had a hand in her death. Dr. Greenson, Marilyn Monroe's psychiatrist at the time of her death, was incensed by the allegations. He sought guidance from the American Psychoanalytic Association whether he should speak out in defense of his deceased patient and others vilified by the statements. The president of the Association told Dr. Greenson he doubted whether any

37 At the time the Supreme Court was asked to review the case, *Sybil*, a story about a woman with sixteen separate personalities, was a national bestseller. It was reviewed as "a psychological document" and as a "moving human narrative," destined "to stand as a significant landmark both in psychiatry and in literature." The woman's psychiatrist, Dr. Cornelia B. Wilbur, met with the author, Professor of English Flora Rheta Schreiber, known to Dr. Wilbur as a psychiatrist editor of *Science Digest* and the author of articles on psychiatric subjects. The doctor believed it would not be sufficient to present this "history-making case" in a medical journal, because the case had broad psychological and philosophical implications for the general public in addition to medical significance.

*Sybil* (a pseudonym) became actively involved in the project and was a frequent visitor in the author's apartment where she discussed her analytic sessions and her home life. The author says, in the preface, that through the ten years she worked on the book she was associated with both Dr. Wilbur and Sybil, who, sometimes separately, sometimes together, stood ready to "sit" for the portrait. As research material the author used Dr. Wilbur's daily notes, jotted in pencil on prescription pads during the course of 2,354 office sessions, Sybil's essays written as part of the treatment procedure, and tapes recorded during the analytic sessions. The author also studied Sybil's diaries, kept from adolescence through the first year of the analysis, letters, family and hospital records, and hometown newspapers and records. Reading the completed manuscript, Sybil remarked, "Every emotion is true." Dr. Wilbur commented, "Every psychiatric fact is accurately represented." F. R. Schreiber, *Sybil* (1973).

38 The *National Tattler* and other sex-and-gore publications as well, published stories about President Kennedy and Marilyn Monroe. One headline read: "Marilyn Monroe Had JFK's Baby Girl." The stories strained credulity, but even if believable, there is no cause of action by a deceased person's estate either for libel or for invasion of privacy of a decedent. Rose v. Daily Mirror, 284 N.Y. 335, 31 N.E.2d 182 (1940); Rome Sentinel Co. v. Boustedt, 43 Misc. 2d 598, 252 N.Y.S.2d 10 (Sup. Ct. 1964); nor can a claim be made by members of a decedent's family for their own anguish based upon statements concerning the decedent. Schumann v. Loew's Inc., 144 N.Y.S.2d 27 (Sup. Ct. 1955).
group can satisfactorily resolve the question for the individual psycho-
analyst facing such a dilemma. Dr. Greenson chose to speak out.

Did anyone who gave credence to Mailer's allegations have a change
of mind as a result of Dr. Greenson's statement? And did the truth
lie only with Dr. Greenson? Could it be that there is no such thing as a
"secret" in the sense that there are no other clues? Is the psychiatrist
the only investigator able to translate clues? Does the psychiatrist have
the unique ability to draw essential insights? With good reason, many
psychiatrists believe the recipient of psychiatric information, which may
be poorly understood, could do as well, or even better, if he applied his
usual method of decision-making.

There are times, though, when reporting by a treating psychiatrist
may be crucial. Conflict may arise between the physician's responsibil-

39 Medical Tribune, Oct. 24, 1973, at 1. It may be noted that the American Bar Associa-
tion and state bar associations have ethics committees that do give such advice.

40 Christopher Lehmann-Haupt, the noted New York Times book reviewer, thought that
"Dr. Greenson was probably justified in speaking out on Marilyn Monroe" because, he
said, "Mailer's record as a writer is sufficiently important that almost anything he does
should be taken with utmost seriousness." Letter from Christopher Lehmann-Haupt to
author, Jan. 21, 1974.

A negative answer is given in a letter to the editor from David F. Musto, Assoc. Prof. of
History and Psychiatry at Yale University. N.Y. Times, Aug. 1, 1973, § 5 at 38, col. 5.

Writing on the artistic quality of graffiti, one author was asked if he checked his ideas
with a psychiatrist. Indignantly, he answered, "Why should I ask a shrink? Would a
physicist consult with an engineer on a matter of physics?"

Indeed, one may ask why psychiatric data is used at all in a legal proceeding in the
face of the adverse criticism. Lawyers and judges can be heard to say, "all psychiatrists
are nuts" and "their testimony is baloney." This bolsters the conclusion that the psy-
chiatrist is summoned to testify only as a ploy. Time and time again, in the offices of
prosecutors and attorneys, judges' chambers, probation and parole departments, we
hear it said: Psychiatric testimony and evaluation are unsubstantiated, unverified,

And in what might be known as "the foresight saga," the psychiatrist is called upon
to predict dangerousness. Increasingly, in order to delimit hospitalization, mental
health codes restrict commitment on the ground only of dangerousness (without de-
fining the term). At the same time the psychiatrist's prediction is belittled as being as
accurate as the flip of a coin. Several articles have discussed the unreliability of the
psychiatrist's prediction of dangerous behavior. See, e.g., Diamond, The Psychiatric
Prediction of Dangerousness, 123 U. Pa. L. Rev. 439 (1974); Ennis & Litwack, Psy-
chiatry and the Presumption of Expertise: Flipping Coins in the Courtroom, 62 Calif.
L. Rev. 693 (1974); Roth, Dayley & Lerner, Into the Abyss: Psychiatric Reliability and

Dr. Elliot Luby, my colleague at Wayne State University, says:

Predicting dangerousness six months from now or a year from now is no better
than random. There is no way of predicting, other than to assume that if you
were dangerous at one time, the probability that you are going to be dangerous
again is greater than someone you would pick off the street at random. But I
honestly do not know if (even) that is true.


Given changing parameters, who if anyone can predict? On chance affecting our
lives, and how to come to terms with the difficulties that arise from chance, see the
excellent book by Leonard Rastrigin, This Chancy, Chancy, Chancy World (1973).
To protect the gullible, predicting the future is against the law in New York, but over
1,000 gypsy "horoscope and card reader-advisers," against whom the ordinance was
designed, are busy engaged in the practice. N.Y. Times, Jan. 31, 1975, at 41, col. 7.
PSYCHOTHERAPY AND CONFIDENTIALITY

ity to an individual patient and to others. The classic example given is that of the school bus driver who asks his physician to keep in confidence the danger of his having an epileptic seizure while driving a bus load of children. In such a situation, reporting by the physician to the authorities is required. Other notable examples are dangerous or contagious diseases, battered children, firearm and knife-wounds, and the reporting on patients in drug abuse treatment programs. (Legislation requiring reporting provides a defense against invasion of privacy or defamation suits.) In the absence of a specific statute mandating reporting, the making of a report is optional under prevailing law. As a general principle, a person has no duty to come to the aid of another unless there is a special relationship giving rise to that duty. A textbook example is a mother who fails to feed her young child and a neighbor who, aware of the situation, does nothing to save the child. The child dies of starvation. The law imposes a duty of care upon the mother but no duty on the neighbor. The neighbor has a right to make a disclosure (providing a defense to a suit for defamation or invasion of privacy), but not a duty to do so. There are critics of the failure of the law to stress the duty of responsibility to others, but where would the law place its limit?

Does the establishment of a therapist-patient relationship present sufficient involvement by the therapist to impose on him an obligation of care for the safety not only of the patient but also of others? Professor John G. Fleming, a leading commentator on the law of torts, argues that a therapist is sufficiently involved to assume some responsibility for the safety not only of the patient himself but also of any third person whom the therapist knows to be threatened by the patient.

43 McNamara & Starr, Confidentiality of Narcotic Addict Treatment Records: A Legal and Statistical Analysis, 73 Colum. L. Rev. 1579 (1973); Psychiat. News, Sept. 18, 1974, at 1, col. 2. These reporting statutes aside, the citizen's duty to provide information depends on the stage of the Government's inquiry. In the investigation stage, the duty is mostly in the negative; that is, the citizen may not conceal the crime, or help the criminal hide or escape. Under state law it is not a crime to fail to come forward and disclose the commission of a crime; what would be punishable is participation in a conspiracy to withhold evidence. On the federal level, however, the law specifies an offense called "misprison of felony" which provides that a person is guilty of misprison when he has "knowledge of the actual commission of a felony" and "conceals and does not as soon as possible make known the same" to the authorities. Convictions under the statute, however, are rare because the courts have held that the Government must prove an "affirmative" act of concealment to make its case.

When a subpoena is issued, the situation changes. In that event, the citizen has an obligation to cooperate. As the Supreme Court put it, "The public has a right to everyman's evidence except for those protected by a constitutional, common law or statutory privilege." The principal exception is the fifth amendment right against self-incrimination. In addition, there are certain privileges that more or less shield specific communications, such as those between an attorney and client, a doctor and patient, a husband and wife, a priest and a penitent. Also, a subpoena can be challenged on the grounds that the evidence sought is immaterial or irrelevant. Oelsner, Just What Does Anyone Have to Tell the F.B.I.? N.Y. Times, May 4, 1975, § E, at 10, col. 3.

44 The ethical codes of socialist countries stress responsibilities more than in the United States. For an excellent discussion, see Sidel, Medical Ethics and Socio-Political Change, in B. Veatch, W. Gaylin, & C. Morgan, The Teaching of Medical Ethics 29 (1973).

This issue was recently raised in *Tarasoff v. Regents of the University of California*. In that case a clinical psychologist at the University of California, believing that a homicide was in the making, had asked the campus police to place his patient under observation but his administrative superior at the clinic countermanded the order, pursuant to his view of confidentiality. The patient, a young immigrant student, had threatened to kill a girl who had rejected him, and about two months later, upon the girl’s return to college, he shot and stabbed her to death. Her parents brought a suit in negligence against the university. The California Court of Appeals ruled that while a duty of care may be owed to a patient, none was owed to third parties, not even an identifiable third party. Moreover, the court said, the plaintiff failed to establish a causal connection between the harm done and the defendant’s conduct. It could not be shown, the court said, that the failure to act was the proximate cause of the death inasmuch as the patient could have done the same thing even if he had been hospitalized.

The history of tort law reveals a gradual expansion of the concept of duty and causation. The *Tarasoff* case, as resolved by the California Supreme Court in 1974, is only the most recent illustration. Aware that it would be setting a legal precedent, the California Supreme Court deliberated over the case for fourteen months. The Court, in a 5-2 decision, ruled on Christmas eve of 1974, that a doctor or psychotherapist who has reason to believe that a patient may injure or kill another must notify the potential victim, his relatives, friends or the authorities. Chief Justice Matthew O. Tobriner wrote:

[A] patient with severe mental illness and dangerous proclivities may, in a given case, present a danger as serious as foreseeable as does the carrier of a contagious disease or the driver whose condition or medication affects his ability to drive safely.

Our current crowded and computerized society compels the interdependence of its members. In this risk-infested society we

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47 On finding what was formerly a “remote” cause to be an actionable “proximate” cause, Judge Andrews in his dissent in *Palsgraf v. Long Island R.R. Co.*, said, in a frequently quoted statement on the concept of proximate cause: “[I]t is all a question of fair judgment, always keeping in mind the fact that we endeavor to make a rule in each case that will be practical and in keeping with the general understanding of mankind.” 248 N.Y. 339, 355, 162 N.E. 99, 104 (1925) (dissenting opinion). The line between remote and proximate cause has become fainter as society has come to rely increasingly on insurance and other methods of loss-sharing.

Mich. House Bill 5010 (1975) seeks to put the *Tarasoff* decision in statutory form; the proposal would require “professionals treating mentally ill persons to notify any intended victims of threats of harm the mentally ill person makes.” Passage is deemed unlikely.

48 13 Cal. 3d 177, 529 P.2d 553, 118 Cal. Rptr. 129 (1974). The question in *Tarasoff* was the right to bring an action, not the evidence in support of the complaint. The California Supreme Court held that difficulties in showing causation do not require the dismissal of a right of action. Given a right of action, the case now goes to trial or settlement on its merits.
can hardly tolerate the further exposure to danger that would result from a concealed knowledge of the therapist that his patient was lethal.\textsuperscript{49}

The case aroused the psychiatric community. In a press interview, Dr. David Allen, former president of the Northern California Psychiatric Association said, "If it's publicly known that psychiatrists are required to report these things, then the patient will be less likely to talk about it." Dr. Maurice Grossman, chairman of the American Psychiatric Association's committee on confidentiality, commented, "The soundest practice is to try to defuse a person's homicidal urges through treatment. The minute you report him, he drops out of therapy." And he added, "If you locked up everybody who made a threat, there wouldn't be enough room in the hospital."\textsuperscript{50} And in what way does notifying the intended victim protect him? Dr. Grossman opines: "Nothing short of disappearing protects him" and "a hotheaded family might harm the patient to avoid being harmed."\textsuperscript{51} Indeed, it is suggested that from the threatened person's point of view, a warning to him may be far worse than useless. It may cause him, "for an indefinite period, to live under extreme anxiety which itself may induce mental illness. . . ."\textsuperscript{52}

The decision gives rise to further questions: How is an idle or remote threat to be distinguished from an immediate one? Must the psychiatrist report every homicidal fantasy? Would a doctor be liable if he failed to report a vague threat that the patient eventually acted upon? What is "danger"? A teacher, for example, may be deemed harmful to young children because of his sexual conduct. Should the psychiatrist report him? If so, to whom? The school principal? The police?

In the aftermath of the case the following notice was posted at Lafayette Clinic, Detroit: "As per usual the court has established a vague middle ground with no well-defined rule for making a legal judgment. For the time being, it is probably better to err in the favor of overcaution. It is a state ruling, that of California, but it can be used as a precedent for rulings in other states." The \textit{Psychiatric News} in a page-one story said that the decision "could drastically alter the future of physician-patient confidentiality . . . ."\textsuperscript{53}

Various mental health organizations submitted amicus curiae briefs in support of a rehearing. In a step more unusual than not, the California Supreme Court agreed to rehear the case.\textsuperscript{54} The basic arguments urging

\textsuperscript{49} Id. at 183, 185, 529 P.2d at 559, 561, 118 Cal. Rptr. at 135, 137.

\textsuperscript{50} Quoted in N.Y. Times, Dec. 25, 1974, at 15, col. 2.

\textsuperscript{51} Psychiat. News, Feb. 5, 1975, at 18, col. 3.

\textsuperscript{52} Psychiat. News, April 2, 1975, at 17, col. 1. (Quoting from the amicus curiae brief of the American Psychiatric Association.)

\textsuperscript{53} Psychiat. News, Feb. 5, 1975, at 1, col. 1. Consider also:

[The court order] makes psychotherapy with paranoid patients well-nigh impossible. . . . If this decision stands, it will lead to refusal of some therapists to treat paranoid patients or in some anxious therapists to report all threatening utterances to protect themselves. Letter to the editor from Alfred Bronner, M.D., Psychiat. News, April 2, 1975, at 2, col. 3.

\textsuperscript{54} 118 Cal. Rptr. 129 (1975).
modification or reversal were: The enunciated duty to warn is an unworkable standard, since prediction by therapists of violence has a low level of accuracy; breach of confidentiality by warning a potential victim is inconsistent with the therapeutic relationship; and the duty to warn places therapists between the threat of breach of confidentiality on the one hand and penalties for protection of public safety proposed by the decision on the other.

It may be predicted that Tarasoff, modified or unmodified, will not bring in a parade of horribles. Actually, the decision will make little or no difference in the courts, since the court would have to be convinced that the therapist believed that danger was imminent and then did nothing. This would be difficult to establish. The facts of Tarasoff, where the therapist actually reported the danger to the police (but his superior countermanded the request for assistance), is a most unusual set of facts. It is the type of situation that would not likely appear even on a law school examination. Moreover, the decision does not drastically affect the psychiatrist as it has long been the general practice to discreetly

55 The petition for rehearing argued "the inherent unpredictability of violent tendencies."

The petition stated:

The Court's formulation of the duty to warn fundamentally misconceives the skills of the psychotherapist in its assumption that mental health professionals are in some way more qualified than the general public to predict future violent behavior of their patients. Unfortunately, study after study has shown that this fond hope of the capability accurately to predict violence in advance is simply not fulfilled. The burden of this new duty to warn, therefore, is formulated and imposed without reference to the actual ability of the therapist to sustain it.

Petition for reargument, Tarasoff v. Regents of the Univ. of Cal., 13 Cal. 3d 177, 529 P.2d 553, 118 Cal. Rptr. 129 (1974).

The report of the American Psychiatric Association Task Force on Clinical Aspects of the Violent Individual states: "Neither psychiatrists nor anyone else has [sic] reliably demonstrated an ability to predict future violence or 'dangerousness.' Neither has any special psychiatric 'expertise' in this area been established." Quoted in petitioner's brief in support of petition for reargument at 6. Moreover, the petitioner argued, "Even if psychotherapists could accurately predict violent tendencies in their patients . . . the practical problems of whom and how to warn defy description in terms which may be implemented in the day-to-day practice of psychotherapy." Petitioner's brief in support of petition for reargument at 11.

56 The amicus curiae brief of the American Psychiatric Association stated:

While the ultimate aim of psychotherapy may, in some cases, be to enable the patient to better distinguish between fact and fantasy, the treatment itself, at least initially, accords equal and undifferentiated weight to each. To gain the patient's trust [which is] essential to treatment, the therapist must approach the patient's revelations as a form of communication, as an expression of trust, not distinguishing between the factual and fantasy elements thereof. The duty to warn would impose upon psychotherapists a new function disruptive of proper treatment. It would require therapists to make premature judgments attempting to sort from the numerous thoughts, feelings, fantasies, and impulses revealed by the patient those few on which the patient intended to act.


57 To this double-bind the answer is that if the psychiatrist gives a warning as required, and is sued by his patient for invasion of privacy, he can defend on the basis of that right or duty.
warn appropriate individuals or law enforcement authorities when a patient presents a distinct and immediate threat to someone. In *Tarasoff*, the psychotherapist appropriately notified the campus police. "The doctor must act in such cases," says Dr. Alfred Freedman, past president of the American Psychiatric Association. "An immediate threat to someone overrides the necessity of confidentiality in the doctor-patient relationship." States have been enunciated over the years by the American Psychiatric Association on the permissive aspect of breaching confidentiality such as in commitment proceedings.

To argue for strict confidentiality when there has been a distinct threat, coupled with overt activity such as purchasing a gun, is to enunciate an isolated view of one's role. Should the "shrink" shrink away? He might ask himself why the patient has divulged his plans to the therapist. In one way or another an individual may be asking for protection of himself from himself, and protection of others from him. He may be hoping, hoping against hope, that his disclosure will prompt the therapist to exercise control over him.58

The Szaszian view is one of no involvement by the therapist with anyone but the patient, in any type of case.59 It is not clear whether this inflexible formula, to be apodictically applied to every case, is designed to protect the process, the patient or the therapist. Other concerns aside, may not absolute confidentiality and the taking of no responsibility for the patient's conduct at times undermine rather than protect, the therapeutic process? May not disclosure sometimes be warranted, albeit in extremely limited situations? These are rare cases indeed, but they

59 Dr. Emanuel Tanay, an expert on homicide, puts it thusly:

A patient in treatment has the right to expect from his therapist a rescue intervention in the face of realistic danger. To be the perpetrator of a homicide is one of the most self-destructive actions one can take. The therapist as a human being also has an obligation to an innocent victim and, last but not least, he has a duty to his own human dignity. . . . There are many areas where the law has intervened unnecessarily into the practice of mental health professionals. [The *Tarasoff* case] is not such a situation. The decision does not require a therapist to report a fantasy . . . . It simply means that when he is realistically convinced that a homicide is in the making, it is his duty to act like a human being and not like a robot.


Szasz suggests a strict policy of no communication with third parties regardless of whether it is "harmful" or "helpful" for the patient or done with his understanding and consent. For one thing, he says, the distinction between "helpful" or "harmful" is empty because it is often impossible to know in advance the actual consequence of a communication. For another, he says, there is nothing the therapist could communicate to others which the patient does not also know or is not entitled to know. The patient can tell the various people in his life what he wants them to know. Most importantly, he suggests, the therapist should eschew communication with third parties not because he is unable to perform them adequately, but because it distracts from the task which the therapist and the patient have set for themselves. In proportion as the therapist offers extra-therapeutic help, he succeeds in making the therapy a noxious rather than a helpful influence. By doing this, Szasz concludes, the therapist elevates himself to a power position he ought not to have and reduces the patient to that irresponsible position from which the therapy is supposed to rescue him. T. SZA, THE ETHICS OF PSYCHOANALYSIS 172, 185 (1965).
exist. "To everything there is a season," says a biblical maxim, "a time to keep silence, a time to speak."

In the Tarasoff case, the patient was neither defendant nor plaintiff, but suppose that the patient had brought suit against the therapist for failing to hospitalize him. Considering the duty of care owed by a therapist to his patient, might the patient not rightly claim malpractice? Dr. Szasz though would say that the patient would have to seek hospitalization himself, just as he would have to place an order himself if he wanted to buy stock.

The therapist-patient relationship supports affirmative duties not only to the patient but also for the benefit of third parties. A psychiatrist's loyalty to his patient and his responsibility for treating the professional relationship with respect and honor does not negate his responsibility to third persons, to the rest of the profession and to science. Dr. Menninger says that if a patient tells a doctor in confidence that he has brought a time bomb into the hospital and hidden it under the bed of one of the patients, it would be a strange doctor indeed who would feel that this professional confidence should not be violated.

One who is unable to control himself or who feels no responsibility to others must be controlled or brought down to size by the "shrink". This does not involve serving as his delegate (e.g., buying stock for him) but it may require preventing him from harming himself or others. Otherwise expressed, as observers of health care in the Far East have noted, the

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61 The amicus curia brief of the American Psychiatric Association filed in Tarasoff suggested that commitment is the proper solution to the problem presented in the case. It stated:

[1] Instead of attempting to protect an individual potential victim by the slender thread of a warning, the legislature has chosen to treat the source of the problem; namely, the potentially violent person. Pursuit of this course of action is the clinically proper, and the legislatively chosen, method for dealing with potentially violent mental patients; it results in greater protection for society and lesser invasion of the patient's rights than does the court's formulation. Psychiat. News, April 2, 1975, at 17, col. 4. (Quoting from the amicus curia brief of the American Psychiatric Association.)

Actually, the court in Tarasoff in 1974 did not ordain that warning to the potential victim was the only avenue left to the therapist; certification for commitment is a permitted recourse under the decision. In effect, the court ruled, the therapist had to do something, having undertaken care of the patient.

62 K. Menninger, A Manual for Psychiatric Case Study 36 (1960). See also Grossman, Insurance Reports as a Threat to Confidentiality, 128 Am. J. Psychiat. 64 (1971). The lack of "linkages" of data often result in "missed opportunities" in preventing mass killing. A number of persons and agencies may be critically situated to appreciate the violence to come, but each may lack some important perspective as a result of inadequate mechanisms for discreetly recording and transferring important information. The many warning signs in the case of a berserk gunman who shot up a shopping center injuring and killing a number of people is reported in Psychiat. News, Oct. 2, 1974, at 20, col. 1. See also N.Y. Times, Feb. 11, 1975, at 38, col. 3. No patient has a right to exploit a confidential relationship in order to entrap the psychiatrist as a participant in criminal activity. For example, it is considered a conspiracy to defraud the government if a doctor condones a patient who comes to the VA Hospital with certain psychiatric symptoms, and in the course of a session confesses that he has been receiving compensation for self-inflicted wounds, which he had claimed were received in combat.

63 J. Lion, supra note 66; Tanay, supra note 59.
road to recovery is learning to be mindful of others. From Cicero, "Salus populi lex esto" to Mao, "Serve the People." The real question is: What is the best way to defuse a homicidal or suicidal urge?

In principle, there is no rationale in law for making a distinction between outpatients and inpatients, though in the latter case there is a degree of physical control. The cases uniformly say that those charged with the care and treatment of the hospitalized patient must exercise reasonable care to avoid opportunities for aggressive or self-destructive conduct if they "know of facts from which they could reasonably conclude that the patient would be likely to harm himself or others in the absence of preclusive measures." These are elastic terms and, like an accordion, can be compressed to say nothing or expanded to say much.

IV. CONCLUSION

Trust — not absolute confidentiality — is the cornerstone of psychotherapy. Talking about a patient or writing about him without his knowledge or consent would be a breach of trust. But imposing control where self-control breaks down is not a breach of trust when it is not deceptive. And it is not necessary to be deceptive. Indeed, it requires a stretch of the imagination to posit a case where it would be necessary to exercise control without first discussing it with the patient. As a last resort, the therapist typically says something like, "You are afraid of losing control, I'm going to prevent you from doing it." The patient is told that there will be a disclosure, what kind of disclosure and to whom.

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65 See, e.g., Meier v. Ross General Hospital, 69 Cal. 2d 420, 445 P.2d 519, 71 Cal. Rptr. 903 (1968); Vistica v. Presbyterian Hospital, 67 Cal. 2d 465, 432 P.2d 193, 62 Cal. Rptr. 577 (1967). It may be noted that a lawyer under his code of professional responsibility may reveal: confidences or secrets with the consent of the client or clients affected, but only after a full disclosure to them; confidences or secrets when permitted or required by law or court order; the intention of his client to commit a crime and the information necessary to prevent the crime; and confidences or secrets necessary to establish or collect his fee or to defend himself or his employees or associates against an accusation of wrongful conduct. A lawyer possessing unprivileged knowledge of professional misconduct of another lawyer shall report such knowledge to a tribunal or other authority empowered to investigate or act upon such violation. See Disciplinary Rules, DR 4-101, American Bar Association Code of Professional Responsibility (1970).
66 Dr. John R. Lion states the proposition that "violent patients are frightened of their own hostile urges and desperately seek help in preventing a loss of control." He writes:

[V]iolent patients are very much afraid of their own impulses. The homicidal patient . . . wants control furnished so that he will not kill. Therefore, . . . the psychiatrist should assure him that he will not be allowed to act upon his feelings. . . . [The psychiatrist] elicits the emotions and some of the accompanying fantasy, but firmly conveys to the patient that he will be prevented from any violent act. The latter statement is usually most reassuring to the violent patient. J. Lion, Evaluation and Management of the Violent Patient 5 (1972).

As in all areas of life, specific black letter rules are sought as though they were: Holy Grail. They offer comfort and a sense of security. That value notwithstanding, there is need for caution in framing standards of behavior that amount to rules of law. Regulation cannot fairly say when the therapist may divulge, when he should divulge or when he must divulge. In the famous words of Justice Cardozo, "Extraordinary situations may not wisely or fairly be subjected to tests or regulations that are fitting for the common-place or normal."  

Pokora v. Wabash Ry. Co., 292 U.S. 98, 105 (1934). Recently in Bulgaria, I had the occasion to discuss the issue of confidentiality with a physician there. I liked his comments, and the way he phrased them. In his country, he observed, only the state attorney representing the interest of society has the authority to demand communications made by a patient to a physician. Notwithstanding this authority, I was told, the state attorney had not made a demand of my acquaintance during his thirty years of practice, nor any of his colleagues. "Why not?" I asked. "Because," he replied, "it would be a negative influence on social morale. It would be corrupting."  

And I asked, "What about extra-judicial revelations made by a physician in the social interest? Your country I've been told stresses communal responsibility. When do you consider it justified to make a revelation?"

"My dear friend," he replied, "my job is to treat and evaluate workers and to report whether they can return to work, but I have never made a revelation of their communications or of their personal history. And above all please remember that laws are only one guide to conduct. A person should not act as though he were an automaton." Pointing to his head, he went on to say, "To be human is to use one's mind. It is necessary to evaluate the total situation and exercise discretion. Flexibility, dear friend. It so happens that in my experience I have never felt compelled to make a disclosure. But in your country, where I understand so many people have guns, it may be a different situation."